# RELEASE OF INFORMATION FORM

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714-906-1689 office/cell
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## Consent and Authorization to Use or Disclose Confidential Information

I, _____legal representative of _____ (self if adult), hereby authorize the release and exchange of confidential information between **Christine Lister, LMFT** and the following:

Name: _____

Phone/Fax: _____

Email: _____

I understand that I have the right to receive a copy of this authorization and that any cancellation or modification of this authorization must be provided by me in writing and received by Christine Lister, LMFT at the address above to be effective. I understand that I have the right to revoke this authorization at any time.

The purpose/uses/limitations of confidential information and/or records to be disclosed:

_____

_____

_____

I understand that confidential information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable California law may protect such information.

This authorization shall remain valid:

☐ 1-year from date indicated below; Or ☐ upon termination date: _____.

_____ _____

Client Signature Date

_____ _____

Client Signature Date

A photocopy and/or facsimile of this authorization shall be as valid as the signed original on file.